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ABSTRACT

With increasing frequency, psychological services are made available to the consumer via the telephone or computer/telephone link. Historically, information services by telephone have been offered consumers on a variety of subjects when psychopathology is minimal. Immediacy, accessibility, minimal psychological investment, telephone ubiquity, anonymity, and low financial expense are all reasons for maintaining a telephone service. However, potential risks do exist for the caller expecting counseling or psychotherapy, the most important of which may be a degraded level of service. In interpreting "The Ethical Principles of Psychologists" for a majority of cases, a telephone conversation or computer screen display would probably not be considered the context of a professional psychological relationship. Ethically acceptable telephone services include informational services and referral services. Psychologists engaged in telephone services are strongly urged to consider the following recommendations: (1) clearly define the service; (2) educate the public regarding expectations; (3) refrain from advertising or offering pyschotherapy over the telephone in the absence of a patient's compelling psychological evidence that would preclude an office visit; (4) make an effort to refer a caller for psychotherapy consultations; (5) take precautions to compensate for loss of contextual clues; and (6) uphold all relevant principles. (ABL)

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ETHICS AND THE PROVISION OF TELEPHONE CONSULTATION SERVICES BY PSYCHOLOGISTS

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ETHICS AND THE PROVISION OF TELEPHONE CONSULTATION SERVICES BY PSYCHOLOGISTS

Thomas F. Nagy, Ph.D.

STATEMENT OF THE PROBLEM. With increasing frequency psychological services are made available to the consumer via electronic means. The use of the telephone, and, most recently, of interactional computer-telephone link, provides many potential benefits such as ready access to information, advice, and counseling. Indeed, some consumers prefer telephone access to a therapist over face-to-face encounters, despite frequent therapist preference for the latter (Dilley, 1973; Grumet, 1979; Miller, 1973; Rosenbaum, 1977). Potential harm to the consumer may be increased by such practices, however, depending upon variables within both caller and psychologist. As will be seen, expectations and degree of psychopathology present in the caller is as much a factor as the theoretical orientation, training, diagnostic skill and motivation of the therapist. Potential harm and benefit will be examined in this paper, along with the rationale for telephone services and guidelines for providers based on the Ethical Principles of Psychologists.

RATIONALE FOR PROVIDING TELEPHONE SERVICE.

Historically, informational-services have been offered consumers on a variety of subjects when psychopathology is minimal. Information on the following subjects might typically be offered with this type of service: anxiety, chemical addictions, communication, depression, hypnosis, marital problems, sexual dysfunction, sleep, weight loss, etc. Such services, sometimes in the form of pre-recorded messages, provide information about the nature of psychotherapy and different theoretical orientations, and can even function as a referral service.

Immediacy, accessibility, minimal psychological investment, telephone ubiquity, anonymity, and low financial expense are all reasons proffered for maintaining a

telephone service. To be sure, it is far easier for a troubled individual to pick up the telephone and dial a trusted authority for information or counsel than to locate a competent therapist and make an appointment. The latter choice involves a greater commitment emotionally, financially, and temporally than the phone call and fails to produce immediate contact.

When needs are more urgent or a crisis exists "hot-lines" have provided services for decades, operated by hospitals, mental health centers, private organizations, churches, suicide-prevention centers, drug-abuse centers, and many other psychological, medical, and self-help organizations. This has been a means of providing information, giving support during a crisis, or advice re. an urgent situation, and referring to a mental health practitioner when appropriate. Many callers feel helped, by their own report, and they would use the service again.

In other cases where the patient's pathology elicits a tendency to use or even favor the telephone over office encounters a different array of rationales prevail. Patients call for a variety of reasons: 1) to obtain reassurance that support is close by, 2) to satisfy a need for pseudo-intimacy, 3) to achieve some closeness while simultaneously maintaining a safe distance, 4) to express hostile and controlling impulses, and 5) to escape depression and isolation (Chiles, 1974; Miller, 1973; Semel, 1980.). Such calls are generally tolerated or encouraged by therapists and perceived as supportive in nature for the patient in crisis.

There are many cases where the telephone is used as a "transitional tool" for individuals considering entering psychotherapy but unable to do so, for one reason or another (Grumet, 1979). This would be true of the agoraphobic, unable to venture beyond domestic confines, the paranoid, too mistrustful to tolerate the intimacy of the interview situation, and the borderline personality disorder, with overwhelming anxiety about the level of closeness inherent in the psychotherapy setting (Ranan and Blodgett, 1983). Indeed, any potential patient who feels

effectively inhibited from initiating face-to-face therapy but would accept the more oblique approach of a telephone could possibly profit from such an arrangement.

However, potential risks do exist for the caller expecting counseling or psychotherapy, the most important of which may be a degraded level of service provided by one who may have had little or no training conducting these services via telephone. Diagnostic and therapeutic services are most valid, reliable, and effective when an optimal amount of patient data is made available, both by observation and self-report. As will be discussed later, the absence of certain data can, at times, compromise service, resulting in possible harm to the consumer, such as misdiagnosing (overlooking pathology) and/or improper overall case management (improper referral, unwarranted prescriptive advice, etc.). Determining the content of the caller's stated and hidden agenda and maximizing therapeutic effect by the psychologist become the primary tasks. What is being sought and what can ethically be offered within the parameters of sound clinical practice?

UNIQUE ATTRIBUTES OF THE TELEPHONE MEDIUM. Five properties unique to telephone communication are as follows: 1) mechanical, 2) auditory mode restriction, 3) dyadic, 4) spatial, and 5) temporal (Miller, 1973). As will be seen, some of the very properties which constitute potential benefits also are responsible for the problems inherent in telephone services.

Mechanical Property: As a machine, the telephone provides an impersonal medium through which to communicate; a reduced level of sensitivity exists commensurate with reduced expectations by the caller. This machine permits immediate intrusion upon the recipient and demands immediate attention with no regard for the recipient's behavior or mood at the time of the call. At the same time, however, the patient-caller may derive enhanced feelings of safety from using a machine which easily intrudes upon others, quickly meeting psychological needs in a socially acceptable

manner.

Auditory Mode Restriction: The telephone permits only a single-channel means of interaction. Restricting communication to the auditory mode may impoverish the normally rich array of nonverbal exchange in which verbal initiatives are intermittently reinforced continuously by facial expression, respiratory changes, body language, and other consciously and unconsciously visually accessed cues. While such a restriction of information can actually enhance the communication for certain classes of patients and provide an opportunity for fortuitous imagery and fantasy, it may also prevent potentially important data from entering the therapist's decision-making process in diagnosis and treatment.

Dyadic Property: Communication via phone is generally restricted to dyads. This is significantly different from normal day-to-day interaction where an awareness of peripheral cues and persons may play a role. There is the semblance of intimacy, where the speaker's words are intended only for the listener. With the construction of modern telephones the lips of the speaker seem to be only a few inches from the listener's ear. A comparison has been made to the the intimacy of two lovers, where the spoken word or sound in the absence of visual stimulation provides a context reminiscent of physical intimacy, with its attendant conscious and unconscious responses (McLuhan, 1964). Although psychological distance can be more effectively manipulated on the telephone than in other settings it ultimately remains the responsibility of the therapist to monitor and sustain the optimal therapeutic, personal, and professional mix.

Spatial Property: The telephone alters dramatically the spatial relationship of two people, regardless of actual proximity. As long as the individual possesses this machine s/he may "enter the therapist's office" at will. Access is vastly increased, previous psychological and physical barriers eliminated, and the therapist now can be responsible for patients who are physically distant, for whatever reason.

If patient or therapist should leave the geographic area s/he may maintain contact with the other for follow-up or referral (Ranan and Blodgett, 1983; Rosenbaum, 1977). Likewise, supervisor may be contacted by supervisee hundreds of miles distant to continue consultation which had been interrupted by a spatial separation.

Temporal Property: Psychotherapy can be extended to include inter-session contacts, as patient needs demand and sound clinical practice dictates (Chiles, 1974). The patient in crisis can telephone for support at any time; indeed this has been the very cornerstone of crisis-intervention lines in the past, including Alcoholics Anonymous, Recovery Inc., Gateway House, and other self-help and professional "hot-lines".

RELEVANT ETHICAL PRINCIPLES. Principle 4 paragraph k of The Ethical Principles of Psychologists states the following:

> **Individual diagnostic and therapeutic services are provided only in the context of a professional psychological relationship. When personal advice is given by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, mail, or similar media, the psychologist utilizes the most current relevant data and exercises the highest level of professional judgement.**

For a majority of cases a telephone conversation or computer screen display would probably not be considered "the context of a professional psychological relationship"; hence, providing complete diagnostic or therapeutic services solely in this fashion would frequently be unethical. In a crisis situation, however, intervention might be appropriate via such an electronic medium. The task, then, consists of accurate differential diagnosis of "acute" and chronic" pathology. Help might be provided to the acute depressive who contemplates overdosing tonight; immediate intervention with referral for follow-up might be the most appropriate means of coping with such a life-threatening emergency. The caller, however, who wishes to discuss an ongoing marital problem, characterized by chronic poor communication may best be referred for individual or couples therapy instead of

attempting to address the specifics of the case in depth over the telephone.

Principle 2 states that "psychologists recognize the boundaries of their competence and the limitations of their techniques. They only provide services and use techniques for which they are qualified by training and experience" (Principle 2, Preamble). The conducting of psychotherapy via telephone or electronic media in non-emergency situations is not a skill commonly taught in graduate or professional schools. A professional who offers such a service likely does so without prior training or supervision. In the event that a psychologist wishes to offer telephone consultation s/he should be familiar with the relevant literature concerning process and outcome as well as diagnostic categories most amenable to this sort of intervention; risks and benefits to the consumer should be explored along with diagnostic and interactional pitfalls.

The marketing of a telephone psychological service must conform in style and content to the standards set forth in Principle 4, paragraph k: "Psychologists present the science of psychology and offer their services, products, and publications fairly and accurately, avoiding misrepresentation through sensationalism, exaggeration, or superficiality." Where the print or electronic media is used for advertising a telephone service clear and factual statements accurately representing both provider and service are mandated. In making such statements psychologists "are guided by the primary obligation to aid the public in developing informed judgments, opinions, and choices" (Principle 4, paragraph k). These announcements must <u>not</u> contain the following, per the current wording of Principle 4, paragraph b:

> **i) a false, fraudulent, misleading, deceptive or unfair statement;**
> **ii) a misinterpretation of fact or a statement likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts,**
> **iii) a testimonial from a patient regarding the quality of a psychologist's services or products;**

iv) a statement intended or likely to create false or unjustified expectations of favorable results;
v) a statement implying unusual, unique, or one-of-a-kind abilities,
vi) a statement intended or likely to appeal to a client's fears, anxieties, or emotions concerning the possible results of failure to obtain the offered services;
vii) a statement concerning the comparative desirability of offered services;
vii) a statement of direct solicitation of individual clients.

It is perhaps true that some of the very techniques of effective advertising may violate some or all of the above standards for psychologists. A provider might do well to think of advertising messages as announcements, where the purpose is inform or instruct, but never to persuade or convince. It should be noted, however, that Principle 4 was drafted prior to changes in regulations concerning restraint of trade as adopted by the Federal Trade Commission; this principle is currently under revision. A general guide in formulating an announcement message might be found in the Preamble to Principle 6, Welfare of the Consumer: "Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational, or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom of choice with regard to participation."

The manner in which a telephone service is advertised can significantly affect consumer response; that is, a "crisis line" is marketed differently than a "consumer information" number, or some other service. The purpose and goals of the telephone service must be clear in the public eye in order for minimal conditions of informed consent to be met.

CRISIS INTERVENTION. Where crisis-intervention ends and psychotherapy begins is an important distinction in evaluating the ethics of human services by telephone. Motivation of the caller, the existence of a "felt emergency", chronicity of the problem, concurrent ongoing psychotherapy, and credentials and training of the provider are all factors to be considered. Public statements made re. the purpose of

a telephone service is all-important. Is this number a "hot-line" for emergencies only? Is it, instead, a number to call for specific advice re. a human problem involving behavior or affect which has been troubling the caller for some time, but not in an acute way?

For our purpose a crisis shall be defined as a subjectively perceived situation characterized by imminent and significant risk to the physical safety and/or mental health of the caller due in part to psychological distress or impairment. That which is not a crisis but generates sufficient distress to prompt a telephone call seeking help can perhaps best be mediated by means of referral to a mental health professional; the need is apparent but not critical and the response should reflect this difference.

ETHICALLY ACCEPTABLE TELEPHONE SERVICES. Although telephone services will continue to be requested by patients, supervisees, and others and continue to be marketed by psychologists they frequently remain inherently flawed, prompting a word of caution about boundaries and limitations. Three types of service may ethically be offered a consumer by means of the telephone or electronic link:

1) Informational Services (e.g.--information re. mental health, human problems, psychological functioning, etc.), 2) Referral Services (e.g.--aid in selecting a therapist for a specific presenting complaint), and 3) Direct Personal Services (e.g.--crisis intervention, counseling or psychotherapy, consulting, supervising) when significant barriers exist which effectively prohibit an office visit. Counseling or psychotherapy may be provided with an ultimate goal towards face-to-face therapy sessions, unless compelling reasons exist to limit contact to an electronic medium. Questions raised by a caller can result in information supplied by a therapist or a general reply which is not prescriptive in nature regarding a specific resolution or suggested course of action. Due caution should be exercised with all telephone contacts in light of inherent restrictions of the medium and

decreased availability of data, which may result in conscious and unconscious deception, misinterpretation, misdiagnosis, and an overall degraded level of service.

UNACCEPTABLE PRACTICES BY PSYCHOLOGISTS. According to the above-cited standards of the Ethical Principles of Psychologists on-going counseling or psychotherapy via telephone as a primary goal in the absence of initial or planned ultimate face-to-face contact may not always be consistent with sound ethical practice. This is due to factors inherent in the setting which, at times, may limit information gathering essential to a differential diagnosis and result in a possible diminished quality of care in certain patient-therapist dyads. Potentially important information may be vulnerable to patient distortion in the absence of visual cues, such as the age of the patient, the presence of obesity or anorexia, physical disability, ongoing medical condition, tics, as well as a variety of somatic reactions such as muscle tension, blanching or blushing, respiratory changes, and other indices of psychological stress.

Type and extent of patient pathology combined with therapist theoretical orientation and ability to compensate for missing contextual cues account for the major sources of variance in quality of care over the telephone. However, in the type of counseling or therapy where non-verbal cues are not considered additive, risks to the consumer would probably not be appreciably greater than a face-to-face encounter.

The medium of telephone communication may not adequately permit the following: 1) thorough and accurate history-taking, 2) thorough diagnostic assessment, and 3) the whole range of contextual cues. Due to these potential deficiencies, it is possible that the following may also be jeopardized: 1) aligning of therapy priorities and goals, 2) development of an effective treatment plan, 3) establishing criteria for knowing when goals have been met, 4) defining a format for therapy, and

developing commitment to therapy. In the absence of many of these elements a psychologist most probably cannot provide a level of service consistent with the highest standards of practice for a certain range of patients.

GUIDELINES FOR PROVIDERS. Psychologists engaged in telephone services are strongly urged to consider the following recommendations: 1) clearly define the service in a descriptive and explanatory fashion only, 2) educate the public re. expectations and specifics of the service both in advance (by means of announcements in the electronic or print media, or elsewhere) and at the time of the call as well, 3) refrain from advertising or offering psychotherapy over the telephone in the absence of a patient's compelling psychological or physiological evidence that would preclude an office visit, 4) make an effort to refer a caller for psychotherapy consultations rather than engage in problem-solving if it should become clear that the presenting complaint or question is indicative of pathology in need of longer-term remedial efforts, 5) take whatever precautions are deemed necessary to compensate for the loss of the contextual cues, and, 6) uphold all other relevant ethical principles. These guidelines for psychologists are necessarily general in nature; for specific questions re. telephone services psychologists are encouraged to consult with Ethics Committees of APA or the appropriate State Association.

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